INDEPENDENT MEDICAL REVIEW APPLICATION

PATIENT INFORMATION

(If a representative of the patient/enrollee is filling out this form, please provide your contact information on a separate sheet.)

First Name _____ **Middle Initial** _____ **Last Name** _____ **Date of Birth** ___/___/___

Address _____ **Telephone #** _____

City_____ **State** _____ **Zip** _____ **E-Mail** _____

Name of HMO/ Health Plan _____ **Membership I.D.** _____ **Social Security Number** _____

- **Are you a Medi-Cal Managed Care beneficiary?** **YES NO (circle one)**
- **Are you a Medicare or Medicare Plus Choice beneficiary?** **YES NO (circle one)**
- **Have you participated in your HMO's or health plan's grievance process?** **YES NO (circle one)**
- **Has the requested medical treatment or service already been received?** **YES NO (circle one)**

YOUR CONDITION **(Please feel free to continue on a separate page or attach supporting and related documents.)**

- **Please provide a short description of your medical condition or diagnosis** _____
- **What is the medical treatment or service you are requesting?** _____
- **How would you like to see this case resolved?** _____
- **Do you have a condition that is a serious threat to your health? YES NO If YES, please explain** _____
- **Why did your HMO or health plan say it was denying, modifying or delaying services, treatment or reimbursement for emergency care? (check one below)**

_____**Not Medically Necessary** _____ **Experimental or Investigational** **Other:** _____

Please list the physicians who have treated you for this condition. Include their contact information and note whether they were within or outside of your HMO or health plan's network. (Again, feel free to continue on a separate page.)

_____

"I hereby request Independent Medical Review of my dispute with the Health Plan. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information. This authorizes release by and among all medical providers, the enrollee's Health Plan, the California Department of Managed Health Care and its consultants, and any Independent Medical Review Organization or reviewers authorized by the Department of Managed Health Care to review grievances regarding health care services. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a grievance or complaint regarding health care services. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously released pursuant to this authorization. I attest that the information provided is accurate and truthful."

Enrollee's Signature _____ **Date** _____

INDEPENDENT MEDICAL REVIEW

APPLICATION INSTRUCTIONS

Thank you for contacting the Department of Managed Health Care regarding your HMO coverage. We know this is a difficult time and we are here to help. Our Independent Medical Review process can help you when treatment or services have been denied, delayed, or modified by your HMO because the HMO claims that the service is not medically necessary or is experimental. If you need assistance in completing this application form or have any questions, please contact us at 1-888-HMO-2219.

- **This one page application form is all you need to apply for an Independent Medical Review – you do not pay anything for this review.** Providing the requested documents will likely help accelerate the review process.

- Please be aware that failing to apply for Independent Medical Review may forfeit other statutory rights to pursue legal action against your HMO regarding the disputed health care service. Your application may be rejected if it is not submitted within six months of being denied the disputed health care service.

THE APPLICATION

- Please complete the application as fully and accurately as possible. When describing your medical condition, list the physician's diagnosis, e.g., diabetes, cancer, and stroke. Please give us the name of the denied medical service or treatment, or describe it as closely as you can. If available, please provide copies of correspondence about the disputed treatment from your medical group and HMO and attach any other materials or correspondence regarding the disputed service you wish the Department to consider in evaluating your application.

- When listing physicians, please identify those who have seen you for this condition, or from whom you have requested medical service or treatment, or who have recommended for or against you receiving the medical service or treatment. Also identify which physician is your primary care provider (regular physician). Please note whether or not these physicians are within your HMO's network.

- **Please forward documentation and this form, by facsimile or mail, to: Department of Managed Health Care, HMO Help Center, IMR Unit, 980 Ninth Street, Suite 500, Sacramento, CA 95814. If you have any questions, the Department can be reached at 888-HMO-2219, or by fax at 916-229-4328. You will be advised by letter as soon as your case has been accepted for Independent Medical Review.**

- The HMO will be required to provide all medical records in its possession or that are available from contracting providers. **If you have seen non-contracting providers regarding the disputed care, you should take immediate steps to obtain copies of your records from those providers in order to submit them in time for review.** You should submit any all records, documents, or information related to the HMO's denial that you want considered by the reviewers. Please submit copies since originals cannot be returned.

NOTICE REQUIRED BY THE INFORMATION PRACTICES ACT
(California Civil Code Section 1798.17)

The personal information you are being asked to provide to the HMO Help Center is sought pursuant to the laws, primarily the Knox-Keene Act, which authorize and direct the Department of Managed Health Care to regulate health plans and investigate the complaints of health plan enrollees. Such information is primarily used in the investigation of your dispute with the health plan and to obtain an independent medical review. Providing such information is voluntary, not mandatory. However, if you choose not to provide the information, the investigation of your complaint, obtaining an independent medical review and the Department's regulatory functions may be impeded. As a result of the independent medical review and any other investigation, we may disclose such information, as necessary, to the health plan and an independent medical review organization, as well as other government agencies for regulatory and enforcement purposes and as otherwise allowed by law, such as the California Information Practices Act. You have a right to access your personal information by contacting the DMHC Records Request Coordinator, Department of Managed Health Care, Office of Legal Services, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725, (916) 322-6727.